Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 12, 13, 2017	2017_636634_0005	003259-17	Resident Quality Inspection

Licensee/Titulaire de permis

Oneida Nation of the Thames
2212 Elm Avenue R. R.#2 SOUTHWOLD ON N0L 2G0

Long-Term Care Home/Foyer de soins de longue durée

Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni)

2212 Elm Avenue R. R.#2 SOUTHWOLD ON N0L 2G0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ADAM CANN (634), INA REYNOLDS (524), JANETM EVANS (659), JENNA BAYSAROWICH (667)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 21, 22, 23, 24, 28, March 1, 2, 3, 6, 7, and 22, 2017.

The following intakes were completed within this Resident Quality Inspection:

Critical Incident log # 023229-16 / CIS # 3042-000008-16 Critical Incident related to a resident fall.
Complaint log # 031870-16 / IL-47802-LO Complaint related to personal support services and residents rights.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Director of Health and Quality Improvement, the Supervisor of Housekeeping, one Dietitian, the Activity Manager, a Clinical Pharmacy Liaison, two Registered Nurses, eight Registered Practical Nurses, ten Personal Support Workers, one Physiotherapy Assistant, one Housekeeping staff member, one Receptionist, and one Dietary Aide, the Residents' Council Representative, 40 residents and three family members.

The inspector(s) also conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes, and staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, meal and snack services, medication administration and storage areas, and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) Record review was completed of the Treatment Assessment Record (TAR) for a resident. The record said that the resident was to have a dressing change every two days for their wound.

Review of the progress notes and TAR indicated that the resident had not had their dressing changed every two days.

Interview was conducted with a Registered Practical Nurse (RPN). The RPN said that the dressing change was ordered to be changed every two days as per the plan of care but it was not changed as ordered.

Interview conducted with the Director of Health who said that the resident did not receive a dressing change as per the Treatment Assessment Record. [s.6. (7)] (634)

b) A critical incident was submitted by the home to the Ministry of Health. The critical incident stated that a resident sustained an unwitnessed fall resulting in a significant injury.

Record review of the resident's fall history indicated resident had a history of falling.

Review of the plan of care stated that the resident was at risk for falls. The plan of care stated that the resident required the use of special falls interventions.

An observation of the resident was completed and it was noted that the specific falls intervention was not in place. This observation was verified with a Registered Practical Nurse and Activity Aide.

Interview was completed with the Administrator/Director of Care. The Administrator/Director of Care said that due to the resident's history of falls the falls intervention needed to be in place for safety and the care plan should have been followed. [s.6.(7)] (524)

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Review of the Minimum Data Set (MDS) assessments stated a resident was frequently incontinent of bowel.

Record review of the current plan of care indicated the resident was continent of bowel.

Interview was completed with a Registered Practical Nurse (RPN). The RPN said that there was a change in the resident's continence status, where the resident was coded as incontinent of bowel and the plan of care was not revised and should have been.

The licensee had failed to ensure that the resident was reassessed and the plan of care reviewed and revised when resident's care needs changed. [s.6.(10)(b)] (524)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the residents as specified in the plan, and residents are reassessed and the plan of care reviewed and revised when the resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of action, time frames for actions to be taken and any follow-up required; every date on which any response was provided to the complainant and a description of the response and any response made by the complainant.

In an interview a resident, who stated an incident occurred with a Personal Support Worker (PSW) where the PSW allegedly treated the resident disrespectfully which was then reported to Administrator.

The resident stated that the Administrator did not come and tell the resident the outcome of the investigation into the concern.

A review of the complaints log included documentation on a specified date by the Administrator that indicated the resident had placed a complaint related to the PSW. A description of the incident was documented. The Action taken was not dated and no time frames were indicated. The documentation included that the Administrator had met with the resident to review the outcome of the investigation however there was no date or time documented for the interaction. There was no resident response documented.

Interview was completed with the Administrator who acknowledged that the documentation for this complaint incident had not identified dates for the actions or time frames, or the resident's response. [s.101.(2)] (659)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes the type of action taken to resolve complaints, including the date of action, time frames for actions to be taken and any follow-up required; every date on which any response was provided to the complainant and a description of the response and any response made by the complainant, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to inform the Director no later than one business day after the occurrence of the incident of: 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A review of progress notes stated that a resident sustained a fall which was not witnessed and was transferred to hospital. Documentation on Point Click Care stated that the Administrator was notified of the fall with significant injury on a specified date, by a Registered Nurse

The Administrator submitted a critical incident to the Ministry of Health and Long Term Care twenty one days after the incident.

Upon interview with the Administrator, it was said that the home had not notified the Director within one business day of the incident and transfer to hospital with a significant change in status for the resident and should have. [s.107. (3)4] (524)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed no later than one business day after the occurrence of the an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A review of the medication storage area on the west wing was completed. The medication storage room had been locked.

A fridge in the storage room did not have a lock on it and contained an unlocked metal box with injectable Ativan 2 milligram (mg) vials.

In an interview on with a Registered Nurse (RN), the RN said that the expectation was that the metal box in the fridge was to be locked. [s.129. (1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Review of the physician orders and Medication Administration Record (MAR) for a resident showed that the resident was to receive a specific medication before meals.

A medication pass was observed for a specified resident. A Registered Practical Nurse was observed to assess the resident and administered the resident's medication after the resident had finished eating their lunch and exited the dining room.

In an interview with the Registered Practical Nurse (RPN) who administered the medication, the RPN stated that the expectation was that the medication should be given prior to the meal.

Administrator/Director of Care stated that the expectation was that the resident would have been assessed and given their medication, prior to ingesting food. [s.131. (2)] (659)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A medication incident report involved a specific resident who was administered an incorrect dosage of a pain medication. The staff had documented that the he resident had received the correct dosage of medication. The action taken to assess and maintain the resident's health was documented as increased monitoring of pain level, however a review of the resident's clinical record did not show documented evidence to support that monitoring of the resident's pain level was completed.

Documentation on the Medication Incident Report indicated that the physician was not notified as this was a near miss. There was no documentation to show that the resident or family/Substitute Decision Maker (SDM) or the Medical Director were notified of the incident.

A second Medication Incident Report involved a different resident. The report documented that a medication was discontinued with no physician order. Medication Incident Report documentation indicated no harm to the resident. The error was documented as prescribing, transcription/documentation and communication error. There was no documentation to indicate that the resident or SDM or Medical Director were notified of the incident.

A third Medication Incident Report involved a specific resident. It stated a Personal Support Worker (PSW) found medications beside the resident's bed. This incident was identified as a near miss and there was no harm to the resident. The resident missed the scheduled dose of medication. It was documented that the physician was notified via "noted on board". There was no documentation of notification of the resident or SDM or Medical Director.

A fourth Medication Incident Report involved a specific resident. It was documented that a medication was administered and charted as given but the medication had not been administered and remained in the blister pack. Under action taken it was documented as no action as it was a near miss. It was documented that no notification to the physician, resident or family was completed as this was a near miss.

During an interview with a Registered Nurse (RN), the RN stated that they have medication error sheets that they complete when an incident happens. If it is urgent, they notify the doctor by calling him, otherwise it goes on the doctor's board for him to follow

up when he is in. When asked about notification of family or resident of medication incidents, the RN stated they documented this in the progress notes or risk management area on Point Click Care about the medication incidents. The RN stated they have to click off in the risk management program that family have been notified.

A review of the incident progress notes on Point Click Care for the last three months revealed additional medication incidents. There were no documented hard copy medication incidents reports provided to the inspector related to these three incidents.

Interview was completed with the Administrator/DOC who stated that they did not oversee the medication incidents, as the Director of Health and Quality Improvement (DHQI) did. A review of the hard copy of the four medication incidents were reviewed with the Administrator and the DHQI. The Administrator indicated that staff were not always documenting the appropriate type of incident. They stated that if a medication was not given, it was an omission and this is an error, not a near miss. When an error occurs, staff should document if vitals were taken or blood sugar if appropriate, notify physician, complete an incident report, document in the resident chart and notify resident and/or family.

Medication incidents were reviewed with DHQI who acknowledged that the home had not documented all medication incidents in accordance with their procedure. The DHQI also acknowledged that for the four hard copy medication incidents for residents, that they had not all included the immediate actions taken to assess and maintain the resident's health; notification of physician, resident and or SDM. [s.135. (1)] (659)

2. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed (b) corrective action was taken as necessary and (c) a written record was kept of everything required under clauses (a) and (b).

A review of the documentation provided by the licensee for all medication incidents for the last three months included a total of four Medication Incident Reports which had been completed. The four medication incidents were attributed to three staff and there was a corresponding Oneida Long Term Care Incident Report.

The Oneida Long Term Care Incident Report documented the date of the medication incident; who the medication incident was attributed to; the date the incident was

reviewed; a brief description of the medication incident and improvement needed. The bottom of the form under "other" instructions were provided "please sign the bottom of the document indicating that you have read and understood the documentation above, and have completed any corrections Return to reception a.s.a.p".

In interviews with the Administrator and Director of Health and Quality Information (DHQI), the DHQI stated the process was that staff were to complete a medication incident form for all medication incidents and which were to be submitted to the DHQI to investigate. The DHQI met with staff to review the medication incident, usually on their next shift. Staff signed the document and a copy went into the staff members file. The process took a couple of days to complete. The DHQI stated staff should also be documenting in a progress note and on the eMAR if an error was made. The DHQI stated the corrective action was documented on the Oneida LTC incident report as improvement needed. Staff would have received the form in their box in the staff room; the form would have been reviewed together with them and signed. If any improvements were needed such as education it would be documented on this form.

During interviews with the registered staff members involved in the medication incidents, all registered staff stated they did not recall the Oneida Long Term Care Home Incident, meeting with management to review the medication incident or signing the Oneida Long Term Care Home Incident. One RPN stated that they did not recall a medication incident for a specific resident and stated that the initials on the eMAR are documented as `rpn` instead of her own initials.

The DHQI stated that the home did not maintain records of meeting with the staff to discuss the medication incidents and the DHQI was not certain why registered staff would not recall reviewing the Oneida Long Term Care Home Incident with her or the Administrator/DOC or signing the Oneida Long Term Care Home.

During a review of the Medication Incident Reports with DHQI, the DHQI was asked how the home knows who gave medication when the eMAR documented the medication as administered by “rpn”, the DHQI acknowledged this identified a Registered Practical Nurse administered the medication. The DHQI stated we can always identify staff as to who did what. The exception was if an agency nurse worked then they would sign in as agency. The inspector asked if this meant the agency were the "rpn" and the DHQI was not certain.

A medication incident involved a specific resident and was attributed to a specific RPN

on the Oneida Long Term Care Home Incident however the eMAR documented "rpn" instead of the RPN's initials. The DHQI reviewed the eMAR and said it looked like someone was orienting. The DHQI said they could tell from the schedule who worked, the DHQI stated that the RPN on the medication incident form was the one who signed into the eMar. The DHQI said that the RPN was orientating a second RPN. When asked about the medication incident being attributed to the RPN on the medication incident form, the DHQI said that this RPN would have been the one to take the medication out of the cart. The DHQI brought documentation including screen shots to show the inspector that the orientating RPN made the medication error which had initially been attributed to the RPN indicated on the medication incident report.

The DHQI acknowledged the Oneida Long Term Care Home Incident report for the resident was incorrect as the wrong RPN was indicated on the medication incident form. The licensee failed to show evidence that all medication incidents had been reviewed, analyzed and corrective action taken. [s. 135. (2)] (659)

3. The licensee has failed to ensure that :
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

A review of the medication incident analysis dated September - December 2016 was completed and showed a summary of the type of medication incident but did not provide for any area of change or improvement.

A copy of the minutes of the Medical Professional Advisory Committee (MPAC) meetings for June to December 2016 was reviewed. There was no documented meeting in September 2016 noted. The MPAC meeting noted for June 2016 and December 2016 included a section titled "Clinical Consultant Pharmacist Quarterly Report". A notation in this report included that the medication incidents were reviewed with the Director of Care (DOC) but did not include any summary of the medication incidents for the last quarter. This portion of the report also included a section titled, "Results /Recommendations of Action Plan" but there was no documented evidence that these items included in this action plan related to the medication incidents that had occurred for the last quarter.

During an interview, the Director of Quality Health and information (DQHI) stated that the MPAC meetings were quarterly and a review of the medication incidents and adverse drug reactions were completed during the MPAC meetings. When asked about the missing MPAC minutes for September 2016, the DHQI acknowledged an MPAC meeting was not completed in September 2016 and there were only three MPAC meetings held in 2016. The DHQI acknowledged they had never attended a MPAC meeting and was uncertain if areas of change or improvement were discussed at the meetings.

When the DHQI was asked to show evidence that all medication incidents and adverse reactions had been reviewed, they stated that the minutes of the MPAC meetings needed to be clearer. When asked if the documentation showed evidence that all of the medication incidents and adverse reactions were reviewed they said "no". When asked if the results/recommendations of action plan related to medication incidents and adverse events they stated that it appeared the action plan was a more systemic review of what was happening in the home. When asked the expectations for quarterly review of medication incidents and adverse reactions, they stated the expectation was to complete the review quarterly for all medication incidents and adverse drug reactions and that the licensee needed to document and follow any changes and improvements and ensure they are implemented related to medication incidents.

In interviews with the Administrator/Director of Care (DOC), the DOC stated there was discussion at MPAC meetings related to medications, but by the time it got to the meetings the issue had already been dealt with. The Administrator/DOC stated that she did not complete the quarterly review of medications, the DHQI did a review of all incident reports and shared any concerns with the DOC. A review of medication incidents was done with the pharmacist and physician at the MPAC meeting looking for trends and what should be done. The Administrator/DOC was asked to show documented evidence that all medication incidents were reviewed quarterly and documented evidence that changes and improvements identified in a medication incident review were implemented and they said that they could not. [s. 135. (3)] (659)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and main the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class and the pharmacy service provider. Also ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, and corrective action is taken as necessary and a written record is kept, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that they have fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

A resident said that when a specific Personal Support Worker (PSW) made their bed, the PSW asked the resident to leave the room.

In an interview with the PSW, it was stated that the resident was not in their room when the resident's bed was made, we can't make the resident's bed with the resident standing there as there was no room. The Personal Support Worker stated that they have the resident stand outside their room when the resident's bed was made.

The Administrator stated that there was an expectation that the resident was to be present and not asked to leave the room when staff were making the resident's bed. [s.3. (1)1.](659)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours

During stage one of a Resident Quality Inspection, strong odours were observed in a resident's room.

Interview was completed with a Housekeeping staff who said that there was not a specific procedure in place related to lingering offensive odours of resident rooms. The Housekeeping staff entered the resident's room and stated that there was a strong odour in the room.

Interview was completed with Manager of Housekeeping. The Manager of Housekeeping said that the home did not have a procedure or policy to manage all lingering offensive odours.

The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours. [s.87.(2)(d)] (634)

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During observation of the medication pass, a Registered Practical Nurse (RPN) was observed to give the keys to the medication storage area to a Personal Support Worker (PSW). The PSW entered the medication room and obtained an incontinence product and returned the keys to the RPN.

In an interview with the RPN, they stated that the PSW asked the RPN for the key and "because I'm right here and can monitor I gave them the key". The RPN acknowledged that only registered staff were to be in the medication storage room.

In an interview Administrator stated that the expectation was that only registered staff had access to the medication storage area. [s.130.2] (659)

Issued on this 3rd day of May, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.